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IMPLEMENTATION OF A QUALITY ASSURANCE PROGRAM IN A UNITED STATES ARMY MEDICAL TREATMENT FACILITY

Problem-Solving Project Paper

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30 October 1981

SECURITY CLASSIFICATION OF THIS PAGE

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1a. REPORT SECURITY CLASSIFICATION Unclassified	1b. RESTRICTIVE MARKINGS
2a. SECURITY CLASSIFICATION AUTHORITY	3. DISTRIBUTION/AVAILABILITY OF REPORT Approved for public release; Distribution unlimited
2b. DECLASSIFICATION/DOWNGRADING SCHEDULE	
4. PERFORMING ORGANIZATION REPORT ... 88	5. MONITORING ORGANIZATION REPORT NUMBER(S)
6a. NAME OF PERFORMING ORGANIZATION US Army-Baylor University Graduate Program in Health Care Admin/HSHA-IHC	6b. OFFICE SYMBOL (If applicable)
6c. ADDRESS (City, State, and ZIP Code) FT Sam Houston, TX 78234-6100	7a. NAME OF MONITORING ORGANIZATION 7b. ADDRESS (City, State, and ZIP Code)
8a. NAME OF FUNDING/SPONSORING ORGANIZATION	8b. OFFICE SYMBOL (If applicable)
8c. ADDRESS (City, State, and ZIP Code)	9. PROCUREMENT INSTRUMENT IDENTIFICATION NUMBER 10. SOURCE OF FUNDING NUMBERS

PROGRAM ELEMENT NO.	PROJECT NO.	TASK NO.	WORK UNIT ACCESSION NO.

11. TITLE (Include Security Classification)
Implementation of a Quality Assurance Program in a United States Army Medical Treatment Facility

12. PERSONAL AUTHOR(S)
LTC(P) Bruce A. Dalton

13a. TYPE OF REPORT	13b. TIME COVERED	14. DATE OF REPORT (Year, Month, Day)	15. PAGE COUNT
Study	FROM JUL 80 TO OCT 81	OCT 81	16

16. SUPPLEMENTARY NOTATION

17. COSATI CODES			18. SUBJECT TERMS (Continue on reverse if necessary and identify by block number)
FIELD	GROUP	SUB-GROUP	Quality Assurance Program; JCAH Accreditation; Professional Standards Review Organization

19. ABSTRACT (Continue on reverse if necessary and identify by block number)

This study explored the evolution of the Quality Assurance Program through standards established by the Joint Commission on Accreditation and Professional Standards Review Organization. The study identified the initial overall reluctance by the medical profession, but the necessity to establish a mechanism of retrospective review of health care provisions by the practitioners. It provided an applicable approach to the establishment of programs within the military medical treatment facilities. Keywords: Joint Commission of Accreditation For Hospitals, Auditing, Standards, Requirements, Medical Services. (AL)

20. DISTRIBUTION/AVAILABILITY OF ABSTRACT	21. ABSTRACT SECURITY CLASSIFICATION
☒ UNCLASSIFIED/UNLIMITED ☐ SAME AS RPT. ☐ DTIC USERS	

22a. NAME OF RESPONSIBLE INDIVIDUAL	22b. TELEPHONE (Include Area Code)	22c. OFFICE SYMBOL
Lawrence M. Leahy, MAJ(P), MS	(512) 221-6345/2324	HSHA-IHC

DD Form 1473, JUN 86 Previous editions are obsolete. SECURITY CLASSIFICATION OF THIS PAGE

AFZI-MED-CPS 10 June 1981

SUBJECT: Residency Progress Report for the Fourth Quarter - 14 April 1979 - 13 July 1979

THRU: COL Robert J. Summary, MSC
Executive Officer/Preceptor
US Army Medical Department Activity
Fort Meade, Maryland 20755

TO: Residency Committee;
US Army-Baylor University Graduate Program
in Health Care Administration
Academy of Health Sciences, US Army
Fort Sam Houston, Texas 78234

1. In accordance with the instructions contained in the Administrative Residency Manual, subject report is submitted on LTC Bruce A. Dalton, M.D., Administrative Resident and Chief, Professional Services, Kimbrough Army Community Hospital, Fort Meade, Maryland.

a. Residency Assignments during the Period: Reference is made to the submitted Residency Plan for LTC Bruce A. Dalton, MC which was approved by the Residency Committee on 11 October 1978. This residency plan exempted LTC Dalton from the traditional rotational residency. What follows is a summary of my major duties and responsibilities as Chief, Professional Services of Kimbrough Army Community Hospital.

(1) The first nine months of my residency as Chief, Professional Services were spent developing my role as medical director and deputy commander. In retrospect I now recognize a classical error in management. The first task of a good leader must be to delegate appropriate tasks to subordinates. However, I accumulated many additional duties and consolidated many functions in the CPS office. Having belatedly realized this, I began in the fourth quarter an intensive effort in staff development. This was motivated out of a strong sense of survival resulting from the realization that I no longer could satisfactorily perform all self-assigned duties. In addition to staff development, much of my time continued to be devoted to personnel actions, comptroller and budgetary concerns, logistical difficulties, and clinical pursuits. With significant funding constraints, management of continuing health education funds gained added significance in the fourth quarter.

(a) Initial attempts at staff development were complicated by medical staff leadership positions being assigned as obvious additional duties to physicians whose chief interest was in clinical medicine. Only the Department of Medicine had a departmental head who actively participated willingly in administrative matters. My first thrust in staff development was to orient the new Chief, Department of Surgery in his leadership role by emphasizing the administrative duties. From the very beginning it was recognized that departmental matters and patient care would assume equal priority. He committed himself to developing a strong Department of Surgery and has been successful in this desire.

(b) As CPS, I was actually assigned against the TDA line for Chief, Ambulatory Care and Community Medicine. In May, the Fort Meade MEDDAC underwent a Manpower Survey which recognized the need for a full time CPS. With this change in the TDA, I vacated the Ambulatory Care position making available another legitimate leadership position. A promising young inexperienced physician was given this position. He quickly assumed many of my previous duties as he developed the ambulatory care areas.

(c) The Manpower Survey conducted in May provided me with a choice opportunity for staff development. Schedule X's had to be written and job descriptions reviewed. Classes were held for departmental/section chiefs and organizational policies explained. Responsibility for developing and justifying manpower requirements were delegated to the lowest accountability center. The entire staff learned from their efforts and the MEDDAC benefited by an increase in recognized requirements in every area of need. For the first time members of the professional staff recognized the importance of workload accountability and accurate reporting.

(d) Another major element in staff development continued to be physician recruitment. During this quarter I interviewed eleven physicians for possible accession to active duty or hire as civilians. Four of these physicians were eventually hired with the rest being rejected due to poor qualifications or schedule inflexibility. I became even more impressed as to the importance of careful staff selection as the key toward staff development.

(e) In order to maintain some clinical skills, I continued to assist with pediatric night call and rotate on the Emergency Room schedule with the AMIC physicians. The major portion of my clinical time continued to be devoted to serving as Occupational Health Physician. I was becoming more impressed with the importance of Occupational Health and the benefits which accrued from a successful program.

(f) I continued to remain responsible for professional staff continuing health education programs. This consisted of planning the bi-monthly Professional Staff Conference as well as approving all TDY/Administrative Leave requests for continuing health education. Shortage of funds in support of continuing education made close management essential.

(g) The pharmacy and laboratory were beginning to experience supply difficulties thought to be secondary to a recent conversion of accounting procedures from a time-manual to an automated system. I became master of a new logistical vocabulary having to talk in terms of commitments, obligations, order-ship times, due-outs, zero-levels, etc. Policies had to be developed to advise the staff of medication shortages so that alternative drugs could be used. (Little did I realize that this was the beginning of a year long logistical problem which has only recently been resolved.)

(h) Staff development was not confined to Kimbrough Army Hospital. As supervisor of the five outlying MEDDAC clinics in the state of Pennsylvania, I was responsible for their clinic directors also. Clinics at New Cumberland Army Depot, Fort Ritchie, and Fort Indiantown Gap received new OIC's with no prior administrative experience. This and other problems dictated frequent clinic staff visits in order to orient these physicians and supervise clinic operations.

(2) This final Quarterly Management Analysis Project had its beginning early in the residency program and has still not been completely resolved. The removal from practice of an incompetent physician is never a pleasant or easy task. This Quarterly Management Analysis Project is a case study, spanning three years of effort, examining the many difficulties and technicalities encountered when revoking a civil service physician's privileges to practice medicine. It is intended to address the effective and fair use of Credentials Committee in conducting peer review and imposing sanctions.

b. The original residency plan remains unchanged.

c. Professional and Administrative Meetings Attended:

(1) As Chief, Professional Services I continued to chair fourteen MEDDAC and hospital committees and attend several more. Emphasis this quarter was placed on examining committee functions and make them more patient orientated. The Quality Assurance function of each committee was stressed and well defined. Other functions were combined and in some cases deleted if they no longer served a useful purpose. Full participation was encouraged through agenda development and committee attendance strengthened. During this quarter I represented the MEDDAC at the Walter Reed Region Conference. In addition, I represented the MEDDAC Commander at one Post Staff Conference, Fort Meade.

(2) I continued to make at least quarterly staff visits to the five MEDDAC clinics for which I was responsible. Personnel problems developed at the US Army Health Clinic, Tobyhanna Army Depot, which required direct intervention on my part. Solutions included counseling of clinic personnel and a change of clinic director. The clinic has since been most productive and efficient.

d. Educational Experiences:

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(1) In April, I was invited to conduct my first Audit Clinic for the Joint Commission on Accreditation of Hospitals (JCAH) as a member of the Clinical Faculty. At this clinic participants brought sample audits from their hospitals for review and critique. Following two days of teaching the techniques of medical audit, the JCAH announced the revocation of the "audit standard". This old methodology was to be replaced by a new and more comprehensive Quality Assurance standard to be published at a future date. Needless to say, many participants and Clinical Faculty members were unaware of this change and anxiety levels were high. (This was the beginning of a most successful association with the JCAH as a Quality Assurance Clinical Faculty member. It allowed me to actively participate in the development of the new Quality Assurance Standard and make contributions toward its implementation.)

(2) In July I attended the Armed Forces Nuclear Hazards Training Course at Kirkland AFB, New Mexico. This was a most informative and valuable experience. It provided me the necessary background information necessary to conduct medical activities in the event of a nuclear accident, either civilian or military.

e. Status of the PSP and Manuscript: The Manuscript has now been completed and is being typed at this time. The PSP addresses the implementation of the new JCAH Quality Assurance Standard in Kimbrough Army Community Hospital. It will be submitted in final form.

f. Projects: In addition to the activities listed above, there were numerous special projects conducted during the Fourth Quarter.

(1) The most important project in this quarter was the HSC Manpower Survey conducted in late April and early May. One of my major objectives in the survey was to have the position of Chief, Professional Services recognized as a TDA requirement within the command paragraph. At the time of the survey, I was assigned as Chief, Department of Clinics and Community Medicine with additional duty as CPS. This was most unsatisfactory and effectively prevented assigning another physician the duties of Chief, Department of Clinics. This required that job descriptions be developed and work requirements established. The entire CPS role had to be re-evaluated. This effort was completely successful. The Manpower Survey Team not only recognized the need for a full time CPS but recognized the establishment of the CPS office consisting of a GS-5 Secretary-Steno and GS-3 Credentials Clerk.

(2) The Professional and supporting staff were all expanded in areas where workload data was supportive. The MEDDAC adapted a "no-frills" policy toward the completion of Schedule X-a. This emphasized the importance of accurate and representative reporting of workload data. All supervisors within the organization participated in the survey effort and most gained a new appreciation of the complexities of personnel management. The MEDDAC continues to benefit from this exercise.

(3) On 6 June an internal mass casualty exercise was conducted to test the readiness of the hospital. The scenario consisted of a kitchen explosion and gas leak which required fire department interaction before patient evacuation and triage. The medical staff emergency notification procedures were exercised. The hospital learned many lessons from the exercise and these were addressed in a lengthy after-action report. It was my responsibility to command the Emergency Operations Center during the exercise and direct patient care activities. I had developed the scenario with the Plans, Operations, and Training Officer and was extremely pleased with the exercise.

g. Civilian Health Agencies/Institutions Visited: None.

2. Comments/Recommendations: As evidenced by the lateness of this report, I have found it extremely difficult to conduct my duties as Chief, Professional Services as well as maintain my status as resident in the U.S. Army-Baylor Health Care Administration Program. It is my recommendation that the status of physicians who attend this program during the residency year be again reevaluated and that specific guidelines be provided the residents and their preceptors.

BRUCE A. DALTON, M.D.
LTC, MC
Administrative Resident

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I INTRODUCTION

Eight years ago Dr. David Kessner and his co-authors unknowingly announced the emergence of a new movement in the health care industry when they stated: "The question is no longer whether there will be intervention in health services to assure quality, but who will intervene and what methods they will use." (1) The Joint Commission on Accreditation of Hospitals (JCAH), the nationally recognized voluntary accreditation body for hospitals, had just published a new standard utilizing an audit methodology to assist hospitals in the objective review and evaluation of the quality and appropriateness of patient care. In 1972, Congress had directed the Department of Health, Education, and Welfare to develop a government program to ensure the necessity, quality, and cost-effectiveness of medical care financed under federal health care programs. Through this legislation, Professional Standards Review Organizations (PSRO's) were established. The medical profession and the entire health care industry proved reluctant to accept any externally imposed standards of practice and resisted all attempts to do so.

This resistance by the medical profession was not without merit. By definition, for a profession to be recognized and succeed, three principles are generally accepted. First, the privileged position of the specialized dispenser of unique services is best maintained by promoting ignorance on the part of the consumer. Secondly, the profession needs to maintain various controls to limit access to their specialized knowledge and skills, an ideology which stresses client inability to evaluate professional performance. Finally, in order to develop a mutually satisfactory

relationship between professional and client a condition of real or presumed differential knowledge and skills must exist. (2) This fundamentalistic base of the medical profession was already beginning to erode secondary to consumer movements in other segments of the economy.

Consumerism fueled by the successes of Ralph Nader was becoming a dominant socio-economic force. The old concept of "buyer beware" was being replaced by successful litigation dealing with product safety and manufacturer accountability. The medical profession was experiencing an unprecedented increase in the number of legal suits dealing not only with alleged malpractice but with the appropriateness of care rendered. By 1970 most medical staffs had accepted the concept that they were responsible to the governing board of the hospital for the quality of medical care rendered therein. In retrospect it is now obvious that it was only a matter of time before this concept of accountability would have to be extended to the patient-client also. However, the original question still remained: Who was to establish quality assurance mechanisms for the health care industry and what form would they take.

Since PSRO's were limited by legislation to address only federally funded health care programs, the JCAH emerged as an acceptable body to establish quality assurance (QA) mechanisms. A major purpose of the JCAH as stated in its certificate of incorporation was "to promote high quality of care in all aspects in order to give patients the optimal benefits that medical science has to offer." (3) In 1972, the JCAH introduced the Performance Evaluation Procedure for Auditing and Improving Patient Care as a retrospective, primarily outcome oriented approach to ensure quality care by a process of identifying and correcting problems in the provision of health care. (4) In order to reinforce its position on QA in 1974, the JCAH specified the number of medical care audits each accredited institution had to complete yearly, based on hospital size.

Criticism began to be heard that the audit process was too costly in terms of the time demanded of physicians and support staff when compared with observed benefits. It was estimated that each completed medical audit cost the hospital over six thousand dollars. (5) The audit process failed to recognize the validity of clinical judgement and too frequently became a sterile activity to be performed solely for accreditation compliance purposes. Being retrospective, the audit process failed to address current problems and placed too great an emphasis on poor performance outcomes. Most hospitals, however, recognized the value of reviewing the quality of patient care and continued to support JCAH QA efforts. In April 1979, following a complete reappraisal of its QA program, the JCAH Board of Commissioners voted to abolish the old standard dealing with medical audits and develop a more sophisticated, comprehensive approach to quality assurance activities. Gone was the comfortable, well defined audit process to be replaced by a new standard, effective 1 January 1981, emphasizing greater flexibility in assessment methodologies and stressing initiative in implementation at the local level.

The Surgeons General, United States Army, and Commanders, Health Services Command, had consistently supported a policy of JCAH accreditation for military hospitals. It was deemed desirable to have military hospitals periodically subjected to objective evaluations by an external agency of health care professionals in order to maintain a viable and effective health care system. Compliance with nationally accepted standards and subsequent accreditation by the JCAH provided a mechanism for obtaining recognition and credibility for military hospitals within the national health care system. Additionally, JCAH accreditation is required for all hospitals offering approved residency training programs. Since the opportunity for professional advancement through continued education is considered a major retention/recruitment factor for physicians, maintenance of these programs is deemed essential for a viable Army Medical Corps.

Implementation of the new JCAH Quality Assurance Standard presented major problems for many health care institutions. Inherent in the Standard were questions concerning authority, accountability, and organizational structure. These matters, once the private domain of the health care institution, would now be open to inspection and criticism; the bottom line being the institution's ability to demonstrate through appropriate documentation substantial improvements in patient care. A comprehensive program for quality assurance had to be established encompassing all departmental quality related activities and including all supportive services. Many organizational and professional barriers would have to be breached and roles redefined.

Since the JCAH had wisely refused to mandate specific instructions for compliance with the Standard, the problem became one of assuming each hospital's current quality assurance activities and determining what changes needed to be made in order to achieve substantial compliance. Command policies dictated that compliance would have to be accomplished within existing resources and in a manner consistent with the approved organizational structure. It was recognized from the onset that any Quality Assurance Program (QAP) would be an evolutionary process, subject to constant revision and evaluation and unique to each military hospital. There existed no models on which to validate test concepts and the literature provided little insight into the QA process.

The military health care system, however, was better prepared to implement the new JCAH Standard than the civilian health care industry. The concepts of authority, responsibility, and accountability were well founded in military tradition. All military organizations, including hospitals, were constantly subjected to outside evaluation by the Inspectors General, the Army Audit Agency, and legislative special

interest groups. Military hospital management was accustomed to the close review of management process required by the new QA Standard. Military health care providers were already subject to intensive peer review through the Officer/Enlisted Evaluation Report process. The validity of patient-client participation in the military health care process had already been firmly established. All that remained was to overlay JCAH Standard requirements on the existing structure and make those modifications required to achieve an acceptable conformity.

FOOTNOTES

(1) D.M. Kessner et al, " Assessing Health Care Quality - The Case for Travis," N. Eng. J. Med. 288: 189, 1973.

(2) A.I. Kisch and L.G. Reider, "Client Evaluation of Physician Performance," J. Health and Human Behavior 10: 57, 1969.

(3) Joint Commission on Accreditation of Hospitals (JCAH), Accreditation Manual for Hospitals, 1981 ed., p. ix.

(4) A. Vanazunos et al, " Principles in QA," Quality Review Bulletin, special ed., fall 1979, p. 4.

(5) Dale Schumacher, personal communication, 1979.

II LITERATURE REVIEW

Although the provision of quality health care has been a recognized concept since the advent of medicine as a profession, the assurance of health care through appropriate process and documentation is relatively recent. Elements of this process of QA first appeared in 1918 when the initial standards of the American College of Surgeons used in surveying hospitals stated that "the medical staff (should) review and analyze at regular intervals their clinical experience in various departments of the hospital such as medicine, surgery, obstetrics, and other specialties, the medical records of patients, free and pay, to be the basis for such review and analysis." (1) The purpose of this standard, though not stated, was to establish a mechanism of retrospective review of health care by practitioners for peer review purposes. Quality of care as it related to the actual patient was still beyond questioning.

In 1933, Dr. Lee and Jones defined quality of medical care in terms of eight "articles of faith": the scientific basis for the practice of medicine; preventive as opposed to reactive medical care; consumer-provider cooperation in health care; treatment of the patient as a whole individual; the establishment and maintenance of a patient-physician relationship; comprehensive and coordinated medical services; social services as an integral component of medical care; and the accessibility of care for all people. (2) Even at this time, the question of quality of care delivered was still not addressed. Quality assurance was still assumed to be a function of the medical profession with established professional controls adequate for patient-client needs. Hughes, in 1959, observed that in addition to the above, the medical profession collectively presumed to tell society what its needs and desires should be and set the

very terms on which considerations of health care were based. (3) Numerous other authors had addressed this same theme of a self-servient medical profession (4-6); however, it had been pointed out earlier that patients, although reticent in expressing criticism, had definite expectations of their contacts with physicians. (7) Redder et al, in a study of ambulatory patients were able to show that most patients had definite expectations concerning the anticipated therapuetic results from a physician's visit. (8) Clearly, the health care consuming public was beginning to demand more accountability from health care providers.

The decade of the sixties saw the emergence of "consumerism". For the most part this was directed towards goods rather than services. The paucity of literature articles addressing this issue of quality medical care and provider responsibility probably reflects emphasis on other issues such as Medicare/Medicaid and social unrest rather than a lessening of concern. The accreditation standards of the JCAH continued to address facility and system concerns as they related to health care with little emphasis placed on the actual health care encounter. This emphasis was to change secondary to several important events and developments in the early seventies.

Dr. Williamson and colleagues published several articles in the late sixties and early seventies dealing with the utilization of pre-established criteria to assess process and outcome performance in health care. (9-11) They demonstrated that the use of pre-established criteria required health care providers to focus on prognosis, the most critical element in clinical judgement encompassing both diagnosis and therapy. In addition, criteria stimulated concern for the entire well-being of the patient rather than focusing on the more narrow preoccupation with the pathophysiology of the disease process. The third benefit from establishing criteria against which actual

practice could be measured was its impact on continuing education by defining learning needs. (12)

The sharply rising costs of all medical care experienced in the early seventies prompted renewed interest on the part of third-party payors in assuring that maximum benefit be obtained for each health care dollar spent. The emergence of governmental agencies as insurors of the costs of care, first for the aged (Medicare) and later for the underprivileged poor (Medicaid) brought quality concerns into increasingly prominent focus. In 1972, the government responded by creating PSRO's to monitor the quality and appropriateness of care provided through federal funding. Area wide studies were mandated utilizing pre-established criteria to evaluate and establish normative standards. The "medical audit" became recognized as the most valid evaluation tool for QA in medicine. The JCAH adapted this concept and developed an audit methodology designed to assist hospitals in their evaluation and review of patient care. A standard was published making this medical audit process an accreditation requirement. (13) In 1974, the JCAH specified the number of audits to be performed based on hospital size.

Almost immediately articles began to appear questioning the validity and merits of these outcome-based audits. (14, 15) Richardson convincingly pointed out the shortcomings of the audit methodology. (16) He showed that peer judgements of the quality of clinical care derived from criteria based retrospective analysis (audits) of hospital charts were neither sufficiently accurate or homogenous to be of use in decision making by the government or other third-party insurors. Nonetheless, both the JCAH and the PSRO programs on quality assurance continued to focus on removing deficiencies in care identified by retrospective, criteria-based medical audits. (17)

Early in 1974 the Institute of Medicine published its policy statement on the assessment of quality in health care. (18) This statement suggested that very little demonstrable improvement in health status had resulted from maintenance activities currently employed by the health care industry. Concerns with facility improvements and process modifications were important but could not substitute for activities and programs designed to make health care more effective in bettering the health status and satisfaction of the patient population served. The appropriateness of care delivered must be addressed as well as its quality. The impact of medical audit studies on patient care became the "hot" issue in quality assurance. In its 1976 statement on Quality Assurance, the Institute of Medicine was even more critical of the lack of beneficial affects of the audit program. (19) The PSRO's were also being criticized for the lack of demonstrable improvement in patient care attributable to the audit process. (20)

The JCAH, on the other hand, continued to entrench itself in supporting the medical audit as a quality assurance tool. In 1974, the JCAH began publishing a monthly Quality Review Bulletin (QRB) (21) devoted almost entirely to promoting the medical audit process. The QRB published medical, nursing, and multidisciplinary audits stressing their clinical rationales. Particular emphasis was placed on those audits that produced demonstrable benefit to patients. However, most studies were retrospective analyses of patient care documentation with only limited relevance to current practice habits. In an effort to improve the results of the audit process, the JCAH instituted a series of Audit Clinics where the medical audit methodology was discussed by JCAH Department of Education staff and clinical faculty. Clinical faculty members were recruited from the practicing disciplines of the health care system and consisted of professionals who had demonstrated positive results in health care occurring from audit studies. For accredited hospitals, the JCAH numerical

audit requirement was universally regarded as excessively ~~intercessive~~ redundant. Even though the JCAH encouraged local providers to establish their own priorities in conducting QA activities, the audit requirement tended to dominate local concerns.

In 1978, Dr. Williamson again conceptualized and published a new method for conducting quality assurance. (22) He suggested that the failure of medical audits to produce documented improvement in patient health and reducing health care costs was due to application rather than process. The problem was the lack of a practical and effective procedure for selecting study areas where improvement of health or any other target outcome would most likely be achieved.

On 7 April 1979, in an unprecedented action, the Board of Commissioners (BOC) of the Joint Commission on Accreditation of Hospitals voted to abolish the numerical requirement for medical audits specified in Appendix B of the Accreditation Manual for Hospitals. This action, obviously considered due to great pressure from the health care industry, was taken concominant with the introduction of a new QA Standard for hospitals first published in the June issue of the Quality Review Bulletin. (23) In implementing this radical change of policy, the BOC recognized the limitations of the medical audit methodology. (24) Changes in patient care and clinical performance were not in proportion to the amount of time invested and costs associated with the audit activity. In addition, any benefit derived from the audit process was frequently lost in the shuffle of papers that some hospitals felt would satisfy accreditation requirements.

Evaluation of the quality of patient care had evolved to a point at which a more global perspective had to be considered. The intent of the new QA standard was to assist hospitals in implementing an overall quality assurance program designed to

ensure the delivery of optimal patient care. It required that all hospitals have a quality assurance program and that all committees, functions, or activities concerned with QA be integrated and coordinated so that duplication of effort be avoided and existing resources be fully utilized in effective quality assurance activities.

FOOTNOTES

(1) Minimum Standards for Hospitals, Chicago: American College of Surgeons, 1918.

(2) R.I. Lee and L.W. Jones, The Fundamentals of Medical Care, Chicago, University of Chicago Press, 1933.

(3) E. Hughes, "The Study of Occupations," pp. 442-458 in Robert K. Merton et al, (ed.) Sociology Today, New York: Bass Books, 1959.

(4) S. Bloom, The Doctor and His Patient, New York: The Russell Sage Foundation, 1963.

(5) E. Friedson and B. Rhea, "Knowledge and Judgement in Professional Evaluations," American Sociological Review 25: 107-124, 1965.

(6) E. Gross, "When Occupations Meet: Professions in Trouble," Hospital Administration 14: 44-59, 1967.

(7) E. Koos, "Metropolis - What People Think of the Medical Services," American Journal of Public Health 45: 1551-1557, 1955.

(8) G. Reader et al, "What Patients Expect from their Doctors," Modern Hospital 89: 88-94, 1957.

(9) J.W. Williamson, M. Alexander, G.E. Miller, "Continuing Education and Patient Care Research: Physician Response to Screening Test Results," JAMA 201: 938-942, 1967.

(10) J.W. Williamson, M. Alexander, G.E. Miller, "Priorities in Patient-care Research and Continuing Medical Education," JAMA 204: 303-308, 1968.

(11) J.A. Gonella, M.J. Goran, J.W. Williamson et al, " The Evaluation of Patient Care: A New Approach," JAMA 214:2040-2043, 1970.

(12) J.W. Williamson, "Evaluating Quality of Patient Care: A Strategy Relating Outcome and Process Assessment." JAMA 218: 564-569, 1971.

(13) Joint Commission on Accreditation of Hospitals (JCAH): Accreditation Manual for Hospitals, Chicago: JCAH, 1972.

(14) B. Starfield and D. Scheff, "Effectiveness of Pediatric Care: the Relationship Between Process and Outcome," Pediatrics 49: 547-552, 1972.

(15) R.H. Brook and F.A. Appel, "Quality-of-care assessment: choosing a method for peer review," N. Eng. J. Med. 288: 1323-1329, 1973.

(16) F. Richardson, "Peer Review of Medical Care," Medical Care 10: 29-39, 1972.

(17) U.S. Department of Health, Education, and Welfare, Health Care Financing Administration, Office of Health Standards and Quality, PSRO Fact Book, 1977.

(18) Committee of the Institute of Medicine, National Academy of Sciences, A Policy Statement, Advancing the Quality of Health Care, 1974.

(19) Institute of Medicine, National Academy of Sciences, An Evaluation, Assessing Quality in Health Care, 1976.

(20) U.S. Department of Health, Education and Welfare, Bureau of Health Standards and Quality, MCE Evaluation Report, Volume 10 of PSRO Evaluation, Sep 2, 1977.

(21) Quality Review Bulletin. Chicago: Joint Commission on Accreditation of Hospitals.

(22) J. Williamson, "Formulating Priorities for Quality Assurance Activity," JAMA 239: 631-637, 1978.

(23) "New Quality Assurance Standard of the JCAH," Quality Review Bulletin 5: 4-5, 1979.

(24) "Evolution of Quality Assurance Reflected in New Standard," Quality Review Bulletin 5: 2-3, 1979.

III DISCUSSION

Implementation of the new JCAH QA Standard required a re-evaluation of all existing hospital activities addressing quality assurance and integrating them into a functional process which met standard requirements. The Chief, Professional Services became the self-appointed coordinator for implementation of the new Standard. Selected hospital representatives were sent to the JCAH Seminar on Quality Assurance in an effort to gain a better appreciation of JCAH requirements and QA concepts.

The JCAH Quality Assurance Standard

First published in June 1979 (1), the new Standard with its interpretation could at best be described as general guidance. This quality which was first recognized as ambiguity on the part of the JCAH in actuality became a Standard strength. It stressed the importance of each hospital's role in developing its own unique Quality Assurance Program (QAP) which would best meet its needs. Individual and organizational initiative was encouraged. Health Services Command supported this concept when Change 1, Army Regulation 40-400 (and later AR 40-66) was published requiring military hospitals to establish QAP's in conformance with the soon-to-be-published JCAH QA Standard. (2)

The new Standard contained seven major elements required of the hospital's QAP. First, the program had to be comprehensive, transcending all departmental and

organizational boundaries and including all organizational elements. In addition, all hospital QA functions had to be fully integrated into the overall QAP. The purpose of these first two elements was to ensure that the new QAP be cost-effective by eliminating duplication of efforts and achieving maximum dissemination of useful information through enhanced communication.

Each hospital was required to develop a written QA plan. This plan, approved by the Governing Board, was required to specifically address the goals and objectives of the QAP and identify the scope of QA activities to be included. Lines of authority and responsibility had to be clearly identified with accountability for the conduct of the QAP clearly established. A table of QAP organization was suggested as a means of identifying these interactions. The utilization of resources had to be addressed in order to ensure the cost-effectiveness of the QAP. Because each health care facility was unique, it was suggested that the initial plan address implementation procedures and anticipated implementation difficulties. Finally, the written plan was required to specify the mechanism for an annual review of the plan and the entire QAP by the Governing Board.

The Standard also required that a problem-focused approach be utilized for the review and evaluation of patient care and clinical performance. This approach consisted of identifying problems which adversely impacted on patient care and benefit. It discouraged addressing problems external to the organization or those problems for which there was no available solution. Gone was the emphasis on evaluating provider performance or patient care based on operative procedures or diagnosis.

The final and most important element of the new standard required that the

organization be able to document improvement in patient care resulting from QA activities. No longer were studies designed expressly to document quality patient care acceptable. This had been the major cause of the demise of the audit process and the JCAH did not wish to make the same mistake again.

QAP Criteria, Definitions, and Assumptions

Before Kimbrough Army Community Hospital (KACH) could begin to implement the new QA Standard, QAP criteria were established. All agreed that the "KISS" principle should be closely adhered to. By keeping things simple, the program had the greatest chance for organizational utility and acceptance. The program would be existing committee oriented, utilizing the already established committee structure to enhance communication and diffuse information. Functions would be clearly defined but no new committes would be formed. QA would become an agenda item on all appropriatc committees.

Since no additional resources were to be forthcoming in support of the QAP, the program would have to be designed to make maximum utilization of existing resources. This would assure cost-effectiveness and prudent utilization of available manpower, time, and effort.

All QA activities were to be targeted at the lowest accountability center within the organization. For QAP purposes, this lowest center was defined as the smallest organizational work unit capable of instituting policy changes. This usually equated to the departmental or service level. By targeting activities at this level it was anticipated that acceptance would be enhanced since the QAP would not be imposed

from above. In addition, if QA activities were conducted at this lowest level the benefits would be the greatest. Active participation was considered to be the essential element in the success of any QAP.

In keeping with the Standard requirements, the KACH QAP had to represent total organizational involvement. Even though professional staff and peer review were to receive the greatest emphasis, all administrative and support services were to be fully incorporated into the overall QAP. It was recognized that this action might cause some role confusion but the potential organizational/patient-care benefit far outweighed any expected disfunction.

Since the problem-focused approach was required, it became necessary to develop a working definition of the problem concept. It was important that the QAP not be predicated on negative connotations. The QAP must not be threatening to health care providers but rather serve them in their desire to deliver quality care. For the purpose of the QAP, a problem was defined as any deviation from an expected desirable outcome or an area of concern when negative outcome potential exists. This definition encouraged prospective management analysis as well as retrospective performance evaluation.

And finally it was recognized that "quality assurance" itself needed a specific organizational definition. Quality assurance is not quality control. Quality control is a process where well defined outcome parameters can be compared to normative acceptable pre-established criteria. Quality assurance is the evaluation of the management process employed to produce certain pre-determined outcomes. KACH defined quality assurance as that process by which a health care organization ensures the services it renders are optimal consistent with available resources. Quality

assurance activities do not in themselves guarantee quality patient care; they only ensure the establishment of a means to that end.

It was also deemed essential that certain assumptions of quality assurance be accepted by the organization before implementation of the overall program could begin. The first assumption was that the quality of care provided at any given resource level could always be improved. It was this assumption that beget validity to the entire process; for documented improvement in patient care was the pre-established desired outcome.

Secondly, it was a stated assumption that health care providers were personally accountable for their actions. This accountability extended to themselves, their patients, the health care organization, the greater medical profession, and all reimbursement third parties. It is this assumption that provided the basis for peer review inclusion in QA activities.

The third assumption stressed the benefits to be derived from the QAP and its subservient role. It stated that health care providers, given an option, would always choose that course of action most beneficial to their patients. The purpose of the QAP was to identify options for providers as well as fostering a means by which to employ those options. This assumption specifically addressed provider knowledge deficiencies and identified a continuing health education means to correct those deficiencies.

Finally, it was assumed that the QA process must be learned, that it cannot be taught. This represented a commitment on the part of the entire organization to allow for extensive trial and error type learning process. Immediate results were not

to be expected. All QA activities, however meager, were to be encouraged. It was recognized that everyone would benefit and learn from another's efforts. Everyone was acknowledged as an expert in his own field and encouraged to participate at that level.

Implementation of the KACH QAP

The first step toward implementation of the hospital QAP was to assess the present ongoing QA activities and organizational structure. The JCAH self-assessment matrix (3) was a very useful tool in establishing this data base. To no one's surprise, it was demonstrated that many required QA functions were already being adequately performed by the hospital staff. However, no organizational structure existed to identify and compile these efforts into the umbrella program required by the Standard. The first major QA task then became to design a reporting mechanism that would clearly identify the lines of authority and accountability for QA activities.

Figure one, the Quality Assurance Information Flow Chart, was designed to identify QA functions and assign those functions to specific organizational elements. The QA Flow Chart stressed the communication element of the entire QAP. As organizational QA activities progressed from left to right across the chart, higher levels of organizational authority were involved, the highest level being the MEDDAC Commander responsible for all policy formulation and modification. The Chief, Professional Services continued to serve as overall coordinator, responsible to the Executive Committee for monitoring QA activities and directing the reporting mechanism.

Three existing committees were designated "capstone" committees for QA. The Credentials Committee would review all QA studies dealing with peer review and make recommendations for modification of privileges or sanctions directly to the Commander. QA activities would be designed in such a manner as to provide the Credentials Committee with information designed to document the demonstrated current competence of health care providers for consideration in the granting of privileges. The Medical Care Evaluation Committee would review all QA studies dealing with direct patient care concerns and make recommendations to the Executive Committee should policy changes be indicated in order to improve patient care. This committee was also tasked to conduct the Risk Management program within the hospital. The QAP was designed to incorporate the reporting of unusual occurrences as an integral part of QA. A list of generic criteria was developed (figure 2) to assist in risk management efforts. The Utilization Review Committee was designated as the organizational body to review all QA studies dealing with the acquisition and utilization of resources. This included antibiotic utilization review, studies dealing with medical products selection or maintenance, and QA studies concerned with treatment facility safety or utilization.

The next step in implementation was the writing of the hospital QA Plan (Appendix A). This proved to be a relatively simple task since the required background information had already been assembled and a proposed organizational structure identified. It became a simple matter then to concisely address those plan requirements identified above. It was recognized that the plan would represent a working document constantly in need of revision and clarification.

The hospital QAP was now deemed ready to be presented to the organization at large. By this stage of development few people in the hospital were unaware of the new

JCAH QA Standard and cognizant of the hospital's desire to implement the new standard as soon as possible. In order to do this most effectively, a series of ninety minute seminars on quality assurance were planned and held weekly for six weeks. All departmental and service chiefs were required to attend and all other interested hospital staff invited to participate. Schedules were modified and Command support was obtained in order to ensure maximum participation. The purpose of the seminars was to first address new QA concepts and then demonstrate the technique of the problem-focused approach toward quality assurance in the (2) Hospital launched itself into the new era of Quality Assurance in Health Care.

FOOTNOTES

(1) "New Quality Assurance Standard of the JCAH," Quality Review Bulletin 5: 4-5, 1979.

(2) United States Army, "Quality Assurance (Medical Care Evaluation)" Army Regulation 40-400, change 1, Chapter 10, June 1979.

(3) Joint Commission on Accreditation of Hospitals (JCAH): "Seminar on Quality Assurance," QA Workbook, Chicago, JCAH, p. 6-7, 1979.

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REVOCATION OF A CIVIL SERVICE PHYSICIAN'S PRIVILEGES: A CASE STUDY

Quarterly Management Analysis Project
Fourth Quarter

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6 October 1981

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PREFACE

This case study, spanning three years of review and evaluation, examines the many difficulties and technicalities encountered when revoking a civil service physician's privileges to practice medicine. It is intended to address the effective and fair use of the Credentials Committee in conducting peer review and imposing sanctions. In order to provide some degree of confidentiality, names have been changed or deleted. However, the sequence of events and actions are from official records. As such, the information contained herein is privileged, sensitive, and should be considered For Official Use Only.

This study is presented as a chronological account with footnotes. The footnotes represent the author's personal interpretation of the significance of certain actions and the resultant effects. Imposing sanctions against health care providers is never a pleasant task but staff selection and effective peer review are the foundations upon which all other Quality Assurance activities are built.

CASE STUDY

On 30 June 1975, during a period of extreme physician shortage in the U.S. Army Medical Corps, a small MEDDAC located in a sophisticated rural community obtained the medical services of Dr. Key following a lengthy recruitment process. Dr. Key, a 67 year old medical doctor with specialty training in General Surgery, was hired as a General Medical Officer, GS-13, to provide ambulatory care to beneficiaries in the Outpatient Department. Dr. Key's credentials appeared to be in good order with evidence presented of medical training and state licensure. The standard Civil Service recommendations contained no disparaging information. His immediate past employer, an industrial concern, reported that Dr. Key's performance had been satisfactory.[1]

Dr. Key's performance as a physician was first officially questioned by the MEDDAC Medical Care Evaluation Committee on 12 November 1975. A routine chart audit disclosed inadequate documentation and several instances of marginal patient care had been verbally reported to the Chairman by fellow physicians in the Outpatient Department. The Committee recommended that Dr. Key be informed of their concern and the next month's Medical Care Evaluation process specifically address Dr. Key's professional performance.[2] On 6 February 1976, as part of the MEDDAC's initial physician credentialing efforts, Dr. Key was granted temporary privileges to practice medicine pending the completion of the MEDDAC's clinical privileges list. Concern was again expressed by the Credentials Committee regarding certain practices of medicine in the facility by Dr. Key. No specific cases were addressed.

A special Credentials Committee was called on 13 February 1976 for the expressed purpose of "investigating the quality of care being dispensed at this

institution by Dr. Key." The Chief, Pharmacy Service had informed the Committee that Dr. Key was prescribing multiple drugs in the same therapeutic category for patients at a single visit. Patient records of ten such instances were presented to the Committee for evaluation. Additionally, the Chairman presented the Committee with four Memoranda for Record documenting his counseling of Dr. Key for inappropriate medication utilization and punctuality in arriving for work. The Committee recommended that Dr. Key be placed on an immediate 45-day probation during which time he was to submit a list of those drugs he wished to utilize along with indications for their use, common side effects, and interactions or contraindications. The Committee offered, via the minutes, to meet with Dr. Key at his request and discuss these actions with him.[3]

The April 1976 Credentials Committee reviewed the drug list submitted by Dr. Key and accepted it with significant modification. It was noted that Dr. Key had made a good effort to comply with the recommendations of the Credentials Committee. The Committee then recommended that Dr. Key's probationary status be extended for 45 days during which time his prescribing habits would be closely monitored.

On 6 May 1976 Dr. Key was given an Employee Performance Rating of "Satisfactory" for the period 30 June 1975 to 29 June 1976. It was noted that "The employee's ability, conduct, and general character traits are such that retention in the federal service is recommended." This Employee Performance Rating was signed by Dr. Key's immediate supervisor, who also served as Chairman, Credentials Committee, and by the MEDDAC Commander.[4]

Dr. Key's probationary status remained essentially unchanged until April 1977 when he requested and was granted temporary privileges to practice medicine essentially free of previously imposed restrictions. Even though the interim Credentials Committee minutes reflected unfavorably on Dr. Key's performance, no

adverse action was recommended.[5] On 30 June 1977, Dr. Key was awarded a second "Satisfactory" Employee Performance Rating.

On 29 August 1977 an Ad Hoc Credentials Committee meeting was called by the Chairman for the purpose of discussing Dr. Key's practice of medicine. There is no indication that Dr. Key was informed that the meeting was to be held or given any opportunity to attend. The Committee heard testimony from the Chief, Pharmacy Service regarding Dr. Key's alleged misuse of medications. Multiple records were presented to support the allegation. Following a lengthy discussion the Committee recommended that Dr. Key be immediately dismissed or, that not being effected, that he be restricted to giving routine physical examinations and that he not be allowed to prescribe any medications requiring a prescription. On 30 August the recommendation to restrict privileges was approved by the MEDDAC Commander and Dr. Key was so informed.[6]

On 1 October 1977 the health care facility lost its MEDDAC designation and was merged into a larger MEDDAC located approximately one hundred miles distant. At the time of the merger, many functions were absorbed by the new MEDDAC Headquarters including the credentials process. Almost immediately Dr. Key requested in writing a reinstatement of his privileges from the new MEDDAC Commander. In response to this request a team of physicians was dispatched from the MEDDAC hospital to the outlying health clinic to conduct a records review and interview the principals involved. This fact finding team recommended that: Dr. Key be retained on the staff of the health clinic; his practice of medicine continue to be limited to the conduct of routine physical examinations, and the MEDDAC Credentials Committee periodically appraise Dr. Key's performance and make recommendations as to his privileges. The MEDDAC Commander informed Dr. Key of this decision and noted that a reconsideration of his status would be forthcoming in six months.[7] On 8 March 1978 a mass complaint was registered by the medical staff

at the Health Clinic before the U.S. Army Health Services Command Inspector General. The complaint alleged that the MEDDAC Commander had failed to dismiss Dr. Key for documented incompetence to practice medicine. The MEDDAC Commander's response addressed the procrastination of previous peer review committees and reported the findings of the MEDDAC's recent evaluations. He noted that Dr. Key had received satisfactory ratings as a civil servant during every rating period since he began employment and that there was no grounds for or legitimate way in which he could be dismissed.[8]

On 29 June 1978 Dr. Key was again granted a "Satisfactory" Employee Performance Rating for the year beginning 30 June 1977. The MEDDAC Credentials Committee continued to revew Dr. Key's performance on a recurring basis; however, this process was complicated by the failure of the Health Clinic to provide interim reports. In August 1978 a staff visit was made to the Health Clinic by the Chairman of the MEDDAC Credentials Committee in order to receive a current appraisal of Dr. Key's performance. The allegations of Dr. Key's professional incompetence were again stated; however, no documentation was forthcoming. It was also alleged that Dr. Key was having significant memory difficulties and that his physical condition precluded his maximum utilization in the clinic. On obtaining this additional information, the MEDDAC Credentials Committee recommended that Dr. Key be requested to undergo a complete physical examination to include an evaluation of his mental status and recall ability. Dr. Key concurred with this request and the examinations were in fact completed on 30 August 1978. The examinations failed to demonstrate any abnormalities which would impact on Dr. Key's performance of his duties as a physician.[9]

The September meeting of the MEDDAC Credentials Committee again considered Dr. Key's privileges. Since no adverse material was presented regarding Dr. Key's interim performance, the Committee recommended that he be granted

provisional privileges in General Ambulatory Medicine to be reviewed in three months. The newly arrived Health Clinic Commander was requested to serve as Dr. Key's supervising physician and preceptor with the responsibility of keeping the Credentials Committee appraised of his performance.[10] In reality, Dr. Key was still restricted to the performance of physical examinations only since his official job description had been rewritten following previous restrictions in privileges.

At the December 1978 MEDDAC Credentials Committee meeting, the Health Clinic Commander, having supervised Dr. Key for a three month period, stated that he had serious concerns over the ability of Dr. Key to practice medicine. Additional cases of inappropriate utilization of medications were presented for committee consideration. Following a lengthy discussion the Committee unanimously agreed that there was cause for concern and that the suspension of Dr. Key's priviliges must be considered. Due to the complexity of the matter, an Ad Hoc Committee was appointed to conduct a formal review of Dr. Key's competency. In the interim the Committee recommended that Dr. Key continue to perform physical examinations only.

Due to an interim illness and Dr. Key's non-availability this Ad Hoc Committee was not able to meet until June 1979. The meeting was held at the Health Clinic and Dr. Key had been given an agenda two weeks previously detailing the three specific cases to be discussed. Dr. Key appeared before the Committee to defend his management of the three cases and presented additional testimony on his behalf. This Ad Hoc Committee unanimously felt that Dr. Key did not recognize his professional limitations and that he appeared to be deficient in certain areas of medical knowledge. However, the Committee also unanimously felt that on the basis of the three cases presented there was insufficient evidence to revoke Dr. Key's privileges entirely. It was agreed that the reinstatement of privileges to provide medical care and write prescriptions would not be in the best interest of the patients

seen at the Health Clinic. In keeping with the above findings the Ad Hoc Committee recommended to the Credentials Committee that Dr. Key's privileges be restricted to the performance of physical examinations only and that he not be allowed to write prescriptions or dispense medications. The Credentials Committee concurred with this recommendation at its June 1979 meeting.

In December 1979 Dr. Key informally appealed this restriction in privileges to the MEDDAC Commander accompanied by an inquiry as to why he was not granted additional compensation under the Civil Service Comparability Pay Act. The MEDDAC Commander re-affirmed his concurrence with the restriction of privileges and explained that the Civil Service Comparability Pay Act was designed to facilitate the recruitment and retention of physicians. It was noted that neither consideration applied to Dr. Key.

On 29 May 1980 the MEDDAC Credentials Committee met to perform the annual re-appraisal of Health Clinic privileges. It was noted that the Health Clinic Commander had evaluated Dr. Key's performance as "Unsatisfactory" but had provided the Committee with no specific information. The Committee tabled a consideration of Dr. Key's re-appointment pending receipt of specific information from the Health Clinic.

In June 1980 Dr. Key was informed that his supervisor had recommended two unfavorable personnel actions. The first of these recommended withholding the annual Within Grade Pay Increase due to overall performance of duties. This action was appealed by Dr. Key through the Health Clinic Commander to the Merit Systems Protection Board. The decision to withhold the Within Grade Pay Increase was upheld. The second unfavorable personnel action was notification of the intent to submit an "Unsatisfactory" Employee Performance Rating for the period from June 1979 to July 1980. This action was not upheld since Civil Service Regulations require that an employee be personally notified at least ninety days prior to the scheduled

rating date. The supervisor requested a Postponement of Rating; however, this was not favorably considered by the Civilian Personnel Officer. A "Marginally Satisfactory" rating was then submitted.[12] Due to the complexity of these adverse personnel actions it was decided to postpone further action on Dr. Key's credentials until they could be resolved.[13]

In December 1980 the MEDDAC Credentials Committee met once again to consider action on Dr. Key's privileges. Pursuant to the Committee's previous request, the Health Clinic Commander had provided the Committee with specific information and medical records substantiating his "Unsatisfactory" determination. After reviewing the material, the Committee unanimously felt that the evidence of poor practice was so strong that the health, safety, and well-being of the patients seen by Dr. Key were in danger if he were allowed to continue to practice medicine in any form. The Committee recommended that Dr. Key's privileges be revoked immediately pending the results of a formal investigation. An Ad Hoc Committee was appointed to investigate the allegations and report to the full Committee within thirty days.[14] Dr. Key was immediately informed of this decision by the MEDDAC Commander. An Ad Hoc Credentials Committee meeting was scheduled for 5 January 1981 and Dr. Key was provided a detailed agenda including all the negative information considered by the Committee. Seven specific cases were selected for in-depth evaluation and Dr. Key was requested to appear before the Ad Hoc Committee prepared to defend his medical management of those specific cases.

The Committee met as scheduled with Dr. Key in attendance. Discussion was limited to the previously identified cases; however, Dr. Key was allowed to introduce any evidence on his behalf. Following a lengthy meeting the Committee members failed to arrive at a definitive recommendation due to Dr. Key's defense that he had been unable to adequately discharge his duties due to clinic operating procedures. The Committee was unable to evaluate the validity of this defense without additional information.

On 6 February 1981 a visit was made to the Health Clinic by the MEDDAC Administrative Resident for the expressed purpose of studying the administrative procedures followed by the clinic in the conduct of physical examinations. Although the Administrative Resident was provided with specific questions to be addressed, he was not aware of the events which prompted this mission.[15]

On 26 February the Ad Hoc Credentials Committee was again assembled to consider Dr. Key's privileges. The Administrative Resident was called to present his findings and to clarify certain elements. The resident was dismissed and a lengthy discussion followed concerning the relevance of this additional information. The committee members unanimously felt that insufficient documentation had been presented to rule on Dr. Key's competence to practice medicine. The Committee was split on the question as to whether Dr. Key was negligent on the performance of physical examinations and the review of associated lab data. All members felt that Dr. Key's performance had in no way been compromised by the Health Clinic's standard operating procedures as they pertained to the conduct of physical examinations. At the conclusion of this deliberation the MEDDAC Credentials Committee was assembled to formulate a final recommendation.[16]

After due deliberation and full consideration of the documentation presented the MEDDAC Credentials Committee recommended that Dr. Key's privileges to practice medicine and perform physical examinations be permanently revoked. The recommendation was not unanimous. One dissenting member felt that even though negligence existed it did not warrant revocation of privileges. The other dissenting member did not recognize Dr. Key's actions as negligence and, therefore, felt that the recommendation was unwarranted.

Following a thorough review of all documentation and available information, the MEDDAC Commander concurred with the Credentials Committee's recommendation and on 13 March 1981 officially notified Dr. Key of his loss of privileges. Since the

MEDDAC Commander is both the approving and appeal authority, the determination was considered final. The Health Clinic Commander was directed to identify appropriate duties for Dr. Key pending position review by the Civilian Personnel Office.

Since Dr. Key was no longer capable of performing any elements contained within his job description and was at an age which exceeded Civil Service maximums except for physicians, the Civil Service Commission had no alternative but to concur with the Health Clinic's request for termination.

On 24 April 1981, Dr. Key was removed from his position at the Health Clinic and terminated without additional compensation from the Civil Service roles. Dr. Key's only avenue of appeal is through the civilian court system, an option which he has not chosen to invoke.

FOOTNOTES

1. Later attempts to validate referral and training information were unsuccessful due to the failure of schools and agencies to maintain records for longer than three to five years. Dr. Key's duties as "plant physician and surgeon" for the nine years prior to accepting civil service employment represented little direct patient care and were more administrative in nature. It is extremely important to ensure that the recommendations one receives are applicable to the task at hand.

2. No written record was made of this counselling session and there is no documentation that it indeed ever took place.

3. Dr. Key did not avail himself of this opportunity. The actions by the Credentials Committee were taken without allowing Dr. Key to defend himself and his practice of medicine. All adverse actions recommended by the Credentials Committee must ensure that the physician in question has been afforded due process before any action is taken.

4. This "Satisfactory" Employee Performance Rating essentially negated all the adverse information concerning Dr. Key's performance collected over the previous six months. This probationary period rating represented the final opportunity for the separation of Dr. Key on administrative grounds. This "Satisfactory" rating was due in part to the inflexibility of the Civil Serice rating system but resulted more from the reluctance on the part of the supervisor and reviewing official to give a representative evaluation of Dr. Key's demonstrated performance.

5. Although it cannot be confirmed, this action on the part of the Committee may have been intended to place Dr. Key at risk with the intent of documenting poor performance. His current practice had been so restricted that little meaningful evaluation of his competence could be conducted.

6. This action taken by the Committee and concurred with by the Commander afforded no due process to Dr. Key and could not be upheld by Civil Service Regulations or in a court of law.

7. The period of MEDDAC consolidation was characterized by the necessity to restructure many functional elements. It was generally acknowledged that the reluctance to act on the part of the old Credentials Committee may have been motivated in part by the imminent MEDDAC consolidation. This only served to complicate matters and delay actions since previous records were insufficient to support a defendable resolution.

8. This mass IG complaint was inappropriate since it extended privileged peer review activities outside recognized channels and only served to externalize the problem. The HSC IG determined the complaint to be invalid but continued to monitor the problem.

9. The granting of privileges must take into account four major considerations: demonstrated current competence, mental and physical condition, adherence to organizational rules and regulations, and facility capabilities.

10. The importance of adequate documentation of questionable medical practice was emphasized with the preceptor. It should be noted that all Health Clinic physicians

who had been previously associated with Dr. Key had since left the Command and there appeared to be little remaining support for his removal.

11. In taking this action the Committee recognized that it may have restricted Dr. Key's privileges to the point that incompetence might be impossible to substantiate. It was hoped that this formal restriction might prompt a resignation from Dr. Key before even more unfavorable action was taken.

12. The Civil Service Rating Scheme allows for only three determinations: "Outstanding," "Satisfactory," and "Unsatisfactory." The Civilian Personnel Office refused to officially accept the "Marginally Satisfactory" rating but the rating became part of Dr. Key's permanent personnel folder.

13. This action was taken so that there would be no grounds for claiming agency harrassment on the part of Dr. Key. By this time the MEDDAC Credentials Committee Chairman and the Health Clinic's Civilian Personnel Office were closely coordinating actions. The Credentials Committee wished to ensure that administrative and peer review functions remained completely separate.

14. This action was taken in order to ensure Dr. Key's right to due process.

15. The Administrative Resident was chosen so that an unbiased report could be rendered. It was determined that since Dr. Key had used this information in his defense that the Committee could conduct this fact-finding investigation without Dr. Key's direct interaction and without violating his right to due process.

16. The Ad Hoc Credentials Committee had included Civil Service physicians and Active Duty physicians, not members of the MEDDAC Credentials Committee. Membership composition was carefully chosen so that bias would be minimized and peer representation ensured.